

# HEALTH *watch*

## Medicare Announces New Payment System for Home Health

The Health Care Financing Administration (HCFA) recently proposed rules for a new Medicare payment system to help ensure appropriate reimbursements for quality, efficient home-health care.

The proposal continues the efforts of the Clinton Administration and Congress to protect the home-health benefit while curtailing the unsustainable costs and inappropriate payments that began in the early 1990s.

On October 1, 2000, Medicare will begin paying all home-health agencies under a prospective payment system, as mandated by the Balanced Budget Act of 1997 (BBA) and amended by the Omnibus Consolidated and Emergency Supplemental Appropriations Act of 1998.

The new system will complete the transition from the pre-BBA cost-based system, which encouraged inefficiency, waste and abuse. It will replace the BBA-mandated interim payment system that has been in effect since October 1997.

Under the proposed system:

- Medicare would pay home-health agencies for each covered 60-day episode of care. Beneficiaries could receive an unlimited number of episodes of care.
- Medicare would pay home-health agencies at a higher rate to care for those beneficiaries with greater needs. Nurses and other clinical workers at Medicare-certified agencies already use a comprehensive, standardized tool to assess the needs of patients. Payment rates would be

## *New Medicare Information Is Just A Click Away*



Photo Credit: Neil Merino

During early fall 1999, the Oakland (California) Public Library served as the host site for twin celebrities Marian and Vivian Brown (seated) for a Medicare & You media event. The vivacious and energetic Brown twins have appeared in numerous events and regional commercials throughout the San Francisco Bay area. The Oakland event was designed to demonstrate to the news media how easy it is to surf the Web for Medicare information. The event also coincided with the rollout of a massive nationwide mailing of approximately 32 million copies of the *Medicare & You 2000* handbook. Julie Odosin (far left), director of the Oakland Public Library, listens as Henry Tyson, manager of the Customer Relations Branch of HCFA's San Francisco Regional Office (far right) noted the important partnership with the National Library Association, which is helping seniors to access Medicare information via computer throughout the country. "Medicare is committed to helping seniors learn about Medicare coverage and the options that are available to them," Tyson said. Counselors with the Alameda County State Hospital Insurance Program were also on hand to demonstrate the use of the Medicare Web site ([www.medicare.gov](http://www.medicare.gov)). ♦

Mark Manfredi, a health insurance specialist in the San Francisco Regional Office, contributed the cutline.



The *HCFA Health Watch* is published monthly, except when two issues are combined, by the Health Care Financing Administration (HCFA) to provide timely information on significant program issues and activities to its external customers.

NANCY-ANN MIN DEPARLE  
*Administrator*

ELIZABETH CUSICK  
*Director, Office of  
Communications & Operations Support*

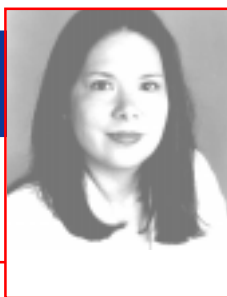
ROBERT K. ADAMS  
*Acting Director, Communications  
Strategies & Standards Group*

#### HEALTH WATCH TEAM

JON BOOTH.....410/786-6577  
JUSTIN DOWLING.....617/565-1261  
WILLIAM KIDD.....Relay: 800/735-2258  
410/786-8609  
MILDRED REED.....202/690-8617  
DAVID WRIGHT.....214/767-6346

Visit Our Web Site!  
[www.hcfa.gov](http://www.hcfa.gov)

You may browse past issues of the *HCFA Health Watch* at [www.hcfa.gov/news/newsltrs/newsltr.htm](http://www.hcfa.gov/news/newsltrs/newsltr.htm). Also, should you wish to make an address change or comment on an article, send your E-mail to [healthwatch@hcfa.gov](mailto:healthwatch@hcfa.gov).



## Message from the Administrator

*Nancy-Ann DeParle*

NANCY-ANN MIN DEPARLE

**A**S WE APPROACH the holiday season, I want to assure the millions of Medicare beneficiaries across the nation that we are ready to pay their Medicare-covered health bills in the next year. We are ready for Y2K.

The Health Care Financing Administration has worked hard to make sure its computers and those at the insurance companies that process Medicare claims will function properly when the calendar flips over to the year 2000.

America moved into the computer age not many years after President Johnson signed Medicare into law, on July 30, 1965 — or 07/30/65 in computer talk.

Using only two digits to denote years saved computer space at the time, but it also created problems that became apparent as the year 2000 neared. For example, some Medicare beneficiaries who were born in 1900 will need health care services in 2000. Without Y2K compliance, both years would show up as 00 on the claims submitted by providers who have treated them.

For us to process Medicare claims and certify coverage in the future, our computers must be able to read years in four digits. This required us to rewrite 50 million lines of computer code. We updated, tested, and retested our systems, and had our work certified by an independent verification and validation contractor. All 25 of our mission critical systems will recognize 01/01/2000 when they read it.

And we had to make sure that the private insurance companies that process and pay Medicare claims for us were ready. The 75 systems they use for this work also have been updated, tested, and certified.

We are confident that when we get a bill from a doctor or other health care provider, we will be able to pay it. Even in the unlikely event that something goes wrong in one of our systems, we do have backups in place.

Of course, it is up to the doctors, hospitals, HMOs, supplemental insurance carriers, and others who serve our beneficiaries, as well as the states, which operate Medicaid and the State Child Health Insurance Program, to get their own computers in order.

We have gone to great lengths to help them with their work. We provided technical assistance, hands-on counseling, free or low-cost software, or whatever else it took.

The most important thing for beneficiaries to remember is that Medicare will cover them, no matter what the calendar says. No computer can make their coverage go away. The best precaution beneficiaries can take is to stay informed. They should talk to their physician or other health care provider and ask them how they are preparing for Y2K.

If problems arise, we will help. Beneficiaries getting a bill that they think should have been submitted to Medicare, or with any other question, need only call our Medicare hotline 1-800-MEDICARE (1-800-633-4227).

Come January 1 and beyond, Medicare will be there for them. ♦

*Wishing You*  
**HAPPY HOLIDAYS**  
*and*  
**GOOD HEALTH**  
*In the Year 2000*

# Walking to Make A Difference...

*To live is so startling it leaves little time for anything else.*  
— Emily Dickinson

More than 2,000 people took part in Avon's Breast-Cancer Three-Day Walk in Atlanta recently. Included were two HCFA Atlanta Regional Office staff, Patricia Bellamy and Vernell Britton, who walked with the others to raise funds for Avon's Breast-Cancer Awareness Crusade. They walked 56 miles from Lake Lanier to Atlanta, sleeping in tents at nightfall for a great cause.

Breast-Cancer Three-Day Walks were initiated by the Avon Company and have been held in several cities. The millions of dollars raised by the walkers will be used to provide education, screening, and direct care to medically needy women throughout the United States.

This year, more than 200,000 women in the United States have been diagnosed with breast cancer; another one million have breast cancer. But not knowing that potentially life-threatening fact, they are likely to remain undiagnosed for five to eight years. Breast cancer is the second leading cause of deaths in women between the ages of 40 and 55. As these walks progressed, more than 40,000 women had died from breast cancer. The best way to "beat" breast cancer is through early detection, regular mammograms for women over 40 years of age, annual clinical exams, and monthly self-exams. The five-year survival rate after treatment for early-stage breast cancer is 97 percent. About two million breast-cancer survivors are alive in America today.

We walked in memory of those who had lost their lives to breast cancer and to breast-cancer survivors, including those currently in treatment. ♦

Vernell Britton, a manager in the Division of Medicaid and State Operations, Atlanta Regional Office, contributed this article.

## Selected Health Issues on the Web

[http://www.access.gpo.gov/su\\_docs/fedreg/a990914c.html](http://www.access.gpo.gov/su_docs/fedreg/a990914c.html)

### *Pharmacy Redesign Demonstration Project*

Medicare-eligible military health system (MHS) beneficiaries' access to pharmacy benefits outside this demonstration project is limited to the facility in which the beneficiary is being treated. This demonstration project will incorporate private sector "best practices" in providing pharmacy services to aged MHS beneficiaries. This URL takes you to the Table of Contents for the *Federal Register*, Vol. 64, No. 177, Tuesday, September 14, 1999. There is one link for this subject (text or PDF) under "Civil Health and Medical Program of the Uniformed Services (CHAMPUS); TRICARE Program — Pharmacy Redesign Demonstration, 49775-49776 [FR Doc. 99-23818]."

[http://www.access.gpo.gov/su\\_docs/fedreg/a990920c.html](http://www.access.gpo.gov/su_docs/fedreg/a990920c.html)

### *Lists of Designated Primary Medical Care, Mental Health, and Dental Health Professional Shortage Areas (HPSAs)*

Public or private nonprofit entities are eligible to apply for assignment to the National Health Service Corps (NHSC) personnel in order to provide primary health services in these HPSAs. This URL takes you to the Table of Contents for the *Federal Register*, Vol. 64, No. 181, Monday, September 20, 1999. There are four links for this subject (text or PDF) under the Health Resources and Services Administration. The links will take you to the various lists of health professional shortage areas around the country.

<http://www.ncqa.org/pages/communications/news/excellentrel.htm>

### *NCQA Recognizes Nation's Best Health Plans With Introduction of New 'Excellent' Accreditation Status*

The National Committee for Quality Assurance (NCQA) recently released the names of an elite group of health plans from across the nation that have earned — by virtue of their commitment to clinical excellence, customer service and continuous improvement — NCQA's new 'Excellent' Accreditation status. Massachusetts, Pennsylvania and New York contain three Medicare managed care plans with the new rating. Florida, Georgia, Texas, Wisconsin, Colorado, California and Hawaii each has one. [Note: The list of all NCQA accredited health plans is available for download from NCQA's Web site. The list is updated on or near the 15th of each month. The health plans listed above had achieved NCQA's "Excellent" designation as of October 18, 1999.] ♦

## PAYMENT from page 1

based on relevant data from the assessment.

- Agencies would receive additional payments for an individual beneficiary if the costs of that care were significantly higher than the specified payment rate. Such “outlier” payments would account for the unusual needs of specific beneficiaries.

- The payment system would use national payment rates, with adjustments to reflect area wage differences and the intensity of care required by each beneficiary.

- The payments would encompass Medicare-covered home-health services for a 60-day episode of care, including skilled-nursing and home-health aide visits, covered therapy, medical social services and supplies.

- Medicare would pay home-health agencies separately for medically necessary durable medical equipment provided under the home-health plan of care.

- Payment rates would be adjusted to reflect significant changes in a patient’s condition during each Medicare-covered episode of care.

- Medicare would require agencies to provide at least five visits to beneficiaries to receive the full payment for each Medicare-covered episode of care. For fewer visits, Medicare would rely on a different methodology to ensure appropriate payments.

HCFA published a proposed rule on October 28, 1999, in the *Federal Register* that details the proposed payment system. The agency will publish a final rule next year after reviewing and responding to the public’s comments.

Medicare has paid hospitals under a prospective payment system since 1983. Medicare began to pay nursing homes under a prospective payment system in 1998. The BBA also requires HCFA to implement prospective payment systems for hospital outpatient services and for rehabilitation hospitals. ♦

## Health, United States, 1999 Reports on Nation’s Health by Spotlighting the Elderly

HHS Secretary Donna E. Shalala recently released a new report showing that a growing and increasingly diverse elderly population in the U.S. is living longer but still faces health challenges as the next century approaches.

*Health, United States, 1999* reveals the annual “report card” on the nation’s health, which is produced by the Centers for Disease Control and Prevention’s (CDC) National Center for Health Statistics (NCHS). The annual report features a special chart book this year on the aging population in the U.S.

Life expectancy for older Americans has increased over the past 50 years. Based on current mortality rates, a 65-year-old person in 1997 could on average expect to live to be nearly 83 years old; an 85-year-old in 1997 could expect to live to be over 90.

Contributing to longer life expectancy is the significant and long-term decline in mortality, especially from heart disease. Death rates from heart disease

among persons 65-84 have been reduced by about half since 1970; among those aged 85 and over, death rates from heart disease have dropped 21 percent over the same time period.

Examining the quality of those added years of life, the report shows that most older persons are not severely limited in their daily activities despite living with chronic conditions. A majority of noninstitutionalized persons 70 years of age and over reported they suffered from arthritis, and approximately one-third reported they had hypertension. Diabetes was reported by 11 percent.

Overall, the report shows that less than 10 percent of noninstitutionalized persons 70 years of age and over were unable to perform one or more activities of daily living (e.g., bathing, dressing, using the toilet) in 1995. However, this disability increased with age from close to 5 percent among persons 70-74 years of age to nearly 22 percent among persons 85 years of age and over.

### Other findings on the health status of the elderly:

- In 1995, 39 percent of noninstitutionalized persons 70 years of age and over used assistive devices such as hearing aids, diabetic and respiratory equipment, and canes and walkers during the previous 12 months.
- Seven out of 10 non-disabled persons 65 years of age and over participated in some form of exercise at least once in a recent two-week period, such as walking, gardening, and stretching. Still, only about one-third of the persons who exercised achieved recommended levels.
- Almost all elderly persons have Medicare coverage. However, non-Hispanic-black and Hispanic elderly persons were less likely than non-Hispanic white persons to have private insurance to supplement their Medicare coverage.
- Approximately 12 percent of Medicare enrollees 65 years of age and over were in managed care plans in 1997. For the U.S. population as a whole, HMO enrollment increased to 29 percent in 1998. ♦

*Health, United States, 1999* features more than a hundred tables showing trends in health status, health risk factors, use of health care and a variety of other health topics for the entire U.S. population collected from several federal and non-federal sources. The National Institute on Aging provided support for the chart book on aging. Copies of the report are available from the NCHS at 6525 Belcrest Rd., Hyattsville, MD 20782, or can be downloaded from the NCHS Web site at <http://www.cdc.gov/nchswww>.

## Medicare HMO Coverage Expands to Beneficiaries in Two Oregon and 13 Oklahoma Counties; 25 Applications Approved, 17 Pending

The Health Care Financing Administration (HCFA) approved a request by Regence HMO Oregon and PacifiCare to expand coverage to Medicare beneficiaries in two Oregon and 13 Oklahoma counties recently.

- **Regence HMO Oregon**, based in Portland, began enrollment in October to serve Medicare beneficiaries starting January 1, 2000, in Marion and Polk counties in northwestern Oregon. In the same area, the plan currently serves beneficiaries in Clackamas, Columbia, Multnomah and Washington counties including Portland. About 38,000 beneficiaries live in the plan's newly approved service area. The plan does business as First Choice 65.

- **PacifiCare**, based in Tulsa, began enrollment in October to serve Medicare beneficiaries starting January 1, 2000. The managed care plan will be offered for the first time to beneficiaries in Cherokee, Lincoln, Mayes and Nowata counties. The plan also will serve beneficiaries throughout nine other counties — Canadian, Creek, Cleveland, Logan, McClain, Okfuskee, Rogers, Tulsa and Wagoner — now partially covered by PacifiCare.

PacifiCare will continue to serve beneficiaries in all of Oklahoma County, including Oklahoma City, and parts of Grady, Osage, Pottawatomie and Washington counties in central and northeastern Oklahoma. About 158,000 beneficiaries live in the plan's newly approved service area. The plan does business as Secure Horizons.

Currently, about 6.5 million Medicare beneficiaries — out of a total of nearly 40 million aged and disabled Americans — have enrolled in Medicare HMOs. HCFA, which administers the Medicare program, has approved 25 applications this year for new or expanded service areas and has an additional 17 applications from managed care organizations seeking to serve beneficiaries in new or expanded service areas. Managed care and other new health care options, known as Medicare+Choice, are available where private companies choose to offer them. Original fee-for-service Medicare,

currently chosen by more than 33 million beneficiaries, is available to all beneficiaries.

Congress created Medicare+Choice in the Balanced Budget Act of 1997 to expand the types of health care options available to Medicare beneficiaries. As part of Medicare+Choice, Medicare now offers new preventive benefits and patient pro-

tections, as well as a far-reaching information program that includes a national toll-free phone number — 1-800-MEDICARE (1-800-633-4227) — a new Internet site — <http://www.medicare.gov> — and a coalition of more than 200 national and local organizations to provide seniors with more information. ♦

## Medicare Part B Premium Unchanged for 2000

The Department of Health and Human Services (HHS) announced recently that the Part B premium paid by Medicare beneficiaries next year will remain unchanged for the second time in three years.

“The Clinton Administration's efforts to protect Medicare are ensuring this essential program will be preserved for the future, and also helping beneficiaries save money,” said HHS Secretary Donna E. Shalala.

The Part B premium covers physician services, hospital outpatient care, durable medical equipment and other services outside hospitals. The Part B premium will stay at the 1999 rate of \$45.50. Last year, it rose by \$1.70.

“This is welcome news for the millions of senior and older Americans who rely on Medicare,” said HCFA Administrator Nancy-Ann Min DeParle.

The Medicare Part A deductible for inpatient hospital care is rising by \$8, only about one percent, to \$776. The small increase largely reflects savings from reductions in Medicare hospital payments and other program changes signed into law in the Balanced Budget Act to help protect and preserve the Medicare Hospital Insurance Trust Fund. Last year, the deductible rose by \$4.

The Part A deductible is a beneficiary's only cost for up to 60 days of inpatient care. The cost to beneficiaries for hospital stays longer than 60 days is rising by \$2, to \$194 per day, and by \$4, to \$388 per day, for stays longer than 90 days. The skilled-nursing facility deductible, which must be paid after the first 20 days of such care, is rising by \$1, to \$97 per day.

The vast majority of Medicare beneficiaries do not pay premiums for Part A coverage. However, these premiums are actually dropping in 2000 for the 365,000 beneficiaries who do not pay them. The full monthly Part A premium is dropping by \$8, to \$301. It is paid by seniors with less than 30 quarters of Medicare-covered employment and by disabled individuals under 65 who lost disability benefits because of work and earnings. Seniors with 30 to 40 quarters of Medicare-covered employment are entitled to reduced premiums that are dropping by \$4, to \$166. ♦

## Medicare to Cover Infusion Pumps for Beneficiaries

After reviewing the scientific evidence of the insulin-infusion pump's effectiveness in treating Type I diabetes, HCFA announced a national coverage decision to cover insulin-infusion pumps in late September 1999. Under the new coverage policy, Medicare will pay for the pump when prescribed for beneficiaries who have Type I diabetes. In Type I diabetes the pancreas fails to produce insulin, the hormone necessary for the metabolism of blood glucose.

The decision to expand Medicare benefits to include insulin-infusion pumps was made within the 90-day deadline HCFA established when it announced a new Medicare administrative process in April 1999. Medicare's new coverage process is designed to be open, understandable and predictable. The process relies on medical and scientific evidence to make national coverage decisions including medical literature and data, discussions with medical experts and technology assessment.

Medicare already covers diabetes self-management training provided in outpatient settings. Blood glucose monitors and testing strips are covered for all diabetic patients as durable medical equipment.

HCFA next will issue a coverage instruction, including coding and billing information, to all of its contractors that will specify the effective date for payment for insulin-infusion pumps for Type I diabetes.

Type I diabetes is less common than Type II diabetes which is more prevalent in the Medicare population. Type I diabetes accounts for 5 to 10 percent of all diabetes in the United States. Type II, a disorder resulting from the body's inability to make enough insulin, accounts for 90 to 95 percent of diabetes. Infusion pumps have not yet been shown to be effective for Type II diabetic patients. ♦

## HCFA Names Members of Remaining Medicare Coverage Advisory Committee

On September 10, 1999, the Health Care Financing Administration (HCFA) named the remaining members of the Medicare Coverage Advisory Committee, who will advise Medicare on coverage policy decisions. Previously, on August 5, HCFA named members of the Laboratory and Diagnostic Services Panel, Drugs, Biologics and Therapeutics Panel, and Medical and Surgical Procedures Panel. [The combined October-November issue of *Health Watch* lists members' names for those panels.]

Additional members of the Executive Committee and members of the Diagnostic Imaging Panel, Durable Medical Equipment Panel, and Medical Devices and Prosthetics Panel have been selected. These selections complete the membership of the new panels, whose expertise will assist Medicare in making timely, science-based coverage decisions using a new administrative process that is easily understood and open to the public.

The coverage committee serves as an advisory body to HCFA on national coverage decisions to ensure Medicare beneficiaries have access to the latest effective, evidence-based treatment. To make national coverage decisions, HCFA relies on medical and scientific evidence including medical literature and data, discussions with medical experts and technology evaluations.

The advisory committee and panels will meet at least twice a year and provide an opportunity for public participation on coverage issues referred to the committee by HCFA. The committee will review and evaluate medical literature, analyze technology assessments, and examine data and information on the effectiveness and appropriateness of medical devices and procedures. Based on the medical evidence reviewed, the committee will advise and make recommendations on Medicare decisions, but HCFA makes final Medicare coverage decisions.

Each of the six advisory panels is organized to roughly parallel Medicare benefit categories, enabling HCFA to obtain the most pertinent technical advice. The panels will be asked to evaluate scientific evidence to assist HCFA in coverage decisions.

The two-year terms of the panel members are staggered with about one-third expiring in 2001, one-third in 2002 and one-third in 2003. The panel and Executive Committee meetings and the administrative record of the coverage decision are public.

In an April 27, 1999 *Federal Register* notice, HCFA described the new administrative process for making national coverage decisions. While building on current procedures, the agency will take additional steps to ensure that the national coverage process is more open, predictable and understandable. The April announcement also outlined how the public may request national coverage decisions, timelines for reviewing requests and the roles of HCFA, the advisory committee and technology assessment in national coverage decisions.

The Medicare law provides for broad coverage of many medical and health care services, including care provided by physicians, hospitals, skilled-nursing facilities and home health agencies. Instead of providing an all-inclusive list of items and services covered by Medicare, Congress gave the Health and Human Services Secretary the authority to decide which specific items and services within these categories can be covered by Medicare.

The law also states that Medicare cannot pay for any items or services that are not "reasonable and necessary" for the diagnosis and treatment of illness and injury. For more than 30 years, the Medicare program has exercised this authority to determine whether specific services that meet one of the broadly defined benefit categories should be covered under the program.

Most Medicare coverage and policy decisions are made locally by HCFA contractors — the private companies that by law process and pay Medicare claims — HCFA also makes coverage policies that apply nationwide and are binding on all contractors and administrative law judges. Under the new administrative process, HCFA will ini-

See **COMMITTEE** on next page

## COMMITTEE from previous page

tiate coverage reviews when appropriate and accept formal requests from external parties for coverage decisions. The agency will typically initiate a national coverage review when there are conflicting local contractor coverage policies, a service represents a significant medical advance and no similar service is covered by Medicare, there is substantial disagreement among medical experts about a service's efficacy or medical effectiveness, or the service is currently covered but is widely considered ineffective or obsolete.

The current membership and affiliations of the three panels and Executive Committee announced on September 10 are as follows.

#### Executive Committee of the Medicare Coverage Advisory Committee (MCAC)

**DIAGNOSTIC IMAGING PANEL** — **David M. Eddy**, M.D., Ph.D., Senior Advisor, Health Policy and Management, Kaiser Permanente Southern California, Washington, D.C.; **Frank J. Papatheofanis**, M.D., Ph.D., Assistant Professor of Radiology, Department of Radiology, University of California San Diego, San Diego, Calif.

**MEDICAL DEVICES AND PROSTHETICS PANEL** — **Harold C. Sox**, M.D., Professor and Chair, Department of Medicine, Dartmouth-Hitchcock Medical Center, Lebanon, N.H.; **Ronald M. Davis**, M.D., Director, Center for Health Promotion and Disease Prevention, Henry Ford Health System, Detroit, Mich.

**DURABLE MEDICAL EQUIPMENT** — **Daisy Alford-Smith**, Ph.D., Director, Summit County Department of Health, Akron, Ohio; **Joe W. Johnson**, D.C., Private Chiropractor, Paxton, Fla.; *Member-at-Large* **Robert H. Brook**, M.D., Sc.D., Vice President and Director, RAND Health and Corporate Fellow, The RAND Corporation, Santa Monica, Calif.; *Consumer Representative* **Linda A. Berthold**, Ph.D., Consultant and Researcher, Stanford, Calif.; *Industry Representative* **Randel E. Richner**, M.P.H., Director, Reimbursement and Outcomes Planning, Boston Scientific Corporation, Natick, Mass.

**DIAGNOSTIC IMAGING PANEL OF THE MEDICARE COVERAGE ADVISORY COMMITTEE** — *Chairperson:* **Donald M. Eddy**, M.D., Ph.D.; *Vice-Chairperson:* **Frank J. Papatheofanis**, M.D., Ph.D. *Voting Members:* **Carole R. Flamm**, M.D., M.P.H., Senior Consultant, Blue Cross and Blue Shield Association, Technology Evaluation Center, Chicago, Ill.; **Jeffrey C. Lerner**, Ph.D., Vice President, Strategic Planning, ECRI, Plymouth Meeting, Pa.; **Michael Manyak**, M.D., Professor and Chairman, Department of Urology, George Washington University Medical Center, Washington, D.C.; **Donna Novak**, B.A., Senior Manager, Deloitte and Touche, LC,

Chicago, Ill.; **Manuel D. Cerqueira**, M.D., Associate Chief, Clinical Cardiology, Georgetown Hospital University Medical Center, Washington, D.C.; **Kim J. Burchell**, M.D., Vice Chair for Hospital Affairs, Department of Surgery, Oregon Health Sciences University, Portland, Ore.; **Steven Guyton**, M.D., M.P.H., Surgeon, Cardiology and Thoracic Surgical Service, Virginia Mason Medical Center, Seattle, Wash.; *Consumer Representative:* **Sally Hart**, J.D., Consulting Attorney, Center for Medicare Advocacy, Tucson, Ariz.; *Industry Representative:* **Michael S. Klein**, M.B.A., Senior Vice President, Marketing and Sales, Varian Oncology Systems, Palo Alto, Calif.

**DURABLE MEDICAL EQUIPMENT PANEL OF THE MEDICARE COVERAGE ADVISORY COMMITTEE** — *Chairperson:* **Daisy Alford-Smith**, Ph.D.; *Vice-Chairperson:* **Joe W. Johnson**, D.C.; *Voting Members:* **Edward A. Eckenhoff**, M.A., M.H.A., President and CEO, National Rehabilitation Hospital, Washington, D.C.; **Halley S. Faust**, M.D., M.P.H., President, Medmax Ventures, LC, Bloomfield, Conn.; **Neil Kahanovitz**, M.D., Orthopaedic Surgeon, Anderson Orthopaedic Clinic, Arlington, Va.; **Lisa Landy**, M.D., Private Practitioner, Tucson, Ariz.; **Kathleen O'Connor**, M.A., Executive Director, WHERE, Seattle, Wash.; **Emil Paganini**, M.D., Section Head, Dialysis and Extracorporeal Therapy, The Cleveland Clinic Foundation, Cleveland, Ohio; **Antonio Puente**, Ph.D., Professor, Department of Psychology, University of North Carolina at Wilmington, Wilmington, N.C.; **Mary Margaret Sharp-Pucci**, Ed.D., M.P.H., Senior Consultant, Blue Cross and Blue Shield Association, Technology Evaluation Center, Chicago, Ill.; **Michael J. Strauss**, M.D., M.P.H., Executive Vice President, Covance, Inc., Washington, D.C.; *Consumer Representative:* **Marilyn-Lu Webb**, Ph.D., Director, Manage Incontinence Positively, Fresno, Calif.; *Industry Representative:* **Jonathan Well**, J.D., Ph.D., Senior Attorney, Medical Products Group/Federal Regulations, Hewlett-Packard Co., Andover, Mass.

**MEDICAL DEVICES AND PROSTHETICS PANEL OF THE MEDICARE COVERAGE ADVISORY COMMITTEE** — *Chairperson:* **Harold C. Sox**, M.D. *Vice-Chairperson:* **Ronald M. Davis**, M.D.; *Voting Members:* **Willarda V. Edwards**, M.D., Managing Partner, Internal Medicine, Baltimore, Md.; **John T. Hinton**, D.O., M.P.H., Vice President, Medical Management, Preferred Physicians Partners, Cincinnati, Ohio; **Anne C. Roberts**, M.D., Professor, Department of Radiology, University of California at San Diego, Medical Center, Thornton Hospital, La Jolla, Calif.; **Karl A. Matuszowski**, M.S., Pharm.D., Director, Technology Assessment Program, Clinical Practice Advancement Center, University Health System Consortium, Oak Brook, Ill.; **Thomas E. Strax**, M.D., Professor and Chairman, Department of Physical Medicine and Rehabilitation, University of Medicine and Dentistry, New Jersey Robert Wood Johnson Medical School, Edison, N.J.; **Wade M. Aubry**, M.D., National Medical Consultant, Health Management Systems, Blue Cross and Blue Shield Association, Technol-

ogy and Evaluation Program, San Francisco, Calif.; *Consumer Representative:* **Rory A. Cooper**, Ph.D., Professor and Chairman, Department of Rehabilitation Science and Technology, University of Pittsburgh, Pittsburgh, Pa.; *Industry Representative:* **Eileen C. Helzner**, M.D., Vice President, Worldwide Clinical Development and Outcomes Research Professional Group, Johnson & Johnson, Titusville, N.J. ♦

## New Regulations/ Notices

**Medicare Program; Appeals of Carrier Determinations That a Supplier Fails to Meet the Requirements for Medicare Billing Privileges [HCFA-6003-P] — Published 10/25.** This proposed rule would extend appeal rights to all suppliers whose enrollment applications for Medicare billing privileges are disallowed by a carrier or whose Medicare billing privileges are revoked, except for those suppliers covered under other existing appeals provisions of HCFA regulations. In addition, we propose to revise certain appeal provisions to correspond with the existing appeal provisions in those other sections of our regulations. We also would extend appeal rights to all suppliers not covered by existing regulations to ensure they have a full and fair opportunity to be heard. Although we are not required by the Administrative Procedure Act to publish this rule as a proposed rule, (see 5 U.S.C. Section 553(b)(3)(A)), we are doing so in order to allow interested parties the opportunity for prior notice and comment. Written comments will be considered if we receive them at the appropriate address, as provided below no later than 5 p.m. Eastern time on December 27, 1999. Mail written comments (1 original and 3 copies) to Health Care Financing Administration, Department of Health and Human Services, Attention: HCFA-6003-P, P.O. Box 26688, Baltimore, MD 21207-0488.

**Health Insurance Portability [45 CFR Subtitle A, Parts 144 and 146] — Published 10/25.** In response to interim regulations published on April 8, 1997, the Departments [DOJ, Labor and HHS] have received comments from the public on a number of

**REGULATIONS** from previous page

issues arising under the portability, access, and renewability provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). The Departments are interested in receiving further comments reflecting the experience that interested parties have had with the interim regulations. The Departments have requested that comments be submitted on or before January 25, 2000. For convenience, written comments should be submitted with a signed original and 3 copies to the Health Care Financing Administration (HCFA) at the address specified below. HCFA will provide copies to each of the Departments for their consideration. All comments will be available for public inspection in their entirety. Comments should be sent to: Health Care Financing Administration, Department of Health and Human Services, Attention: HCFA-2056-NC, P.O. Box 9013, Baltimore, MD 21244-9013.

**Medicare Program; Revision to Accrual Basis of Accounting Policy [HCFA-1876-F] — Published 9/27.** Medicare policy provides that payroll taxes that a provider becomes obligated to remit to governmental agencies are included in allowable costs only in the cost reporting period in which payment (upon which the payroll is based) is actually made to an employee. Therefore, for payroll accrued in one year, but not paid until the next year, the associated payroll taxes are not an allowable cost until the next year. This final rule provides for an exception when payment would be made to the employee in the current year but for the fact the regularly scheduled payment date is af-

ter the end of the year. In that case, the rule requires allowance in the current year of accrued taxes on payroll that is accrued through the end of the year but not paid until the beginning of the next year, thus allowing accrued taxes on end-of-the-year payroll is allowable in the current period rather than in the following period. These regulations are effective November 25, 1999.

**Medicare Program; Telephone Requests for Review of Part B Initial Claim Determinations [HCFA-4121-FC] — Published 9/30.** Currently, our regulations allow beneficiaries, providers, and suppliers, who are entitled to appeal Medicare Part B initial claim determinations, to request a review of the carrier's initial determination in writing. This final rule allows those review requests to be made by telephone and allows the carrier to conduct the review by telephone, if possible. The use of telephone requests supplements, and does not replace, the current written procedures for initiating appeals. This telephone option also improves carrier relationships with the beneficiary, provider, and supplier communities by providing quick and easy access to the appeals process. Carriers will make accommodations to enable a hearing-impaired individual access to the telephone review process. The effective date of these regulations is February 1, 2000.

**Medicare Program; Hospice Wage Index; Correction [HCFA-1039-CN2] — Published 9/16.** On October 5, 1998, HCFA published a notice in the *Federal Register* (63 FR 53446) announcing the annual

update to the hospice wage index, which is used to reflect local differences in wage levels. That update was effective October 1, 1998, and is in the second year of a 3-year transition period. The provisions in this correction notice are effective as if they had been included in the document published in the *Federal Register* on October 5, 1998. On November 1, 1998, HCFA published a notice (63 FR 63326) correcting the October 5 notice. However, HCFA failed to make one typographical correction. Therefore, in FR Doc. 98-26501 of October 5, 1998, we are now making the following correction: On page 53448, in Table A, under the MSA code number 1303 for Burlington, VT, the wage index "1.1037" is corrected to read "1.0137".

**Medicare Program; Optional Coverage of Certain Tuberculosis-Related Services to TB-Infected Individuals [HCFA-2082-P] — Published 9/10.** This proposed rule would amend the existing Medicaid regulations to incorporate statutory provisions that allow States to cover a limited Medicaid service package to an eligibility group of low-income individuals infected with tuberculosis (TB). The services provided under this optional coverage are limited to those related to the treatment of TB. This optional coverage will ensure Medicaid services for the treatment of TB-infected individuals who would otherwise be unlikely to receive coverage under Medicaid. This proposed rule would incorporate and interpret provisions of the OBRA of 1993.♦



Department of Health & Human Services  
Health Care Financing Administration  
7500 Security Boulevard, Mail Stop C5-15-07  
Baltimore, Maryland 21244-1850

OFFICIAL BUSINESS

PENALTY FOR PRIVATE USE, \$300

First Class Rate  
Postage & Fees

**PAID**

HHS Permit No. G-28